

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

9 6 — 1 0

2. STATE:

Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)
Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

7/1/96

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.250 - .280

7. FEDERAL BUDGET IMPACT:

a. FFY 96 \$590,168.50

b. FFY 97 \$2,353,622.20

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D pages 1,2,3,4 and 4.3
Attachment 4.19-D Exhibit B (entire new manual)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-D, pages 1,2,3, and
4
Attachment 4.19-D Exhibit B (entire
old manual)

10. SUBJECT OF AMENDMENT:

Nursing Facility Reimbursement

VERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Review delegated to the Commissioner,
Dept for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

John H. Morse

14. TITLE:

Commissioner, Dept for Medicaid Services

15. DATE SUBMITTED:

Sept 27, 1996

16. RETURN TO:

Department for Medicaid Services
3rd Floor - CHR Bldg
275 East Main Street
Frankfort, KY 40601

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

September 30, 1996

18. DATE APPROVED:

May 16, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 1996

20. SIGNATURE OF REGIONAL OFFICIAL:

Eugene A. Grasser
22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

21. TYPED NAME:

Eugene A. Grasser

23. REMARKS:

NURSING FACILITY REIMBURSEMENT - METHODS AND PROCEDURES

The following sections summarize the methods and procedures for determining nursing facility rates in Kentucky.

Participation Requirements

Nursing facilities currently participating as skilled nursing or intermediate care facilities will be required to participate in the program as a nursing facility (NF) effective October 1, 1990 (the effective date of this change pursuant to OBRA 87). To participate in the Medicaid Program, the facilities will be required to be licensed as nursing facilities (not SNF or ICF) at the time of the first annual survey by the state survey agency which occurs on or after October 1, 1990; at that time, multi-level Medicaid nursing homes will not be recognized, as all nursing care beds in a facility will be considered a part of the same facility. Hospitals providing swing-bed hospital nursing facility care shall not be required to have the hospital beds licensed as NF beds. Hospitals providing dual licensed nursing facility care shall be required to be dually licensed as hospital/nursing facility unless such licensure is not permitted under state licensing statutes; if NF licensure is not permitted by statute, the hospital-SNF/ICF licensure may continue to be used. All nursing facilities (NFs) must participate in Medicare in order to participate in Medicaid, except for those NFs with waivers of the nursing requirements (who are prohibited by statute from participation in Medicare). Any Medicare participating NF may take high intensity care (Medicare skilled nursing care equivalent) and/or low intensity care (the former ICF care equivalent) patients; NFs with a waiver of the nursing requirement (i.e., non-Medicare participating NFs) may take only low intensity patients since the facility is not considered as being adequately staffed to care for high intensity care patients. In the interim (until facilities are surveyed), current skilled nursing facilities participating in Medicare may accept both high and low intensity patients. Current intermediate care facilities not participating in Medicare may accept low intensity patients.

Cost Reports

Facilities shall use an uniform cost reporting form and submit it each year. The single state agency shall set a uniform rate year for NFs and ICF-MRs (July 1-June 30) by taking the latest available cost data which is available as of May 16 of each year and trending the facility costs to July 1 of the rate year.

1. If the latest available cost report period cost data has not been audited or desk reviewed prior to rate setting the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the rate year, the desk review or audited data shall be used.
2. Partial year, or budgeted cost data may be used if a full year's data is unavailable. Unaudited reports shall subject to adjustment to the audited amount.
3. Facilities paid on the basis of partial year or budgeted cost reports shall have their reimbursement settled back to allowable cost, with usual upper limits applied.
4. Facilities whose rates are subject to settlement back to cost shall not be included in the array until the facilities are no longer subject to cost settlement.

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5. The single state agency will modify the cost report form to provide for the distinct cost categories necessary to match with the nursing assessment data for case mix implementation.

Audits

The state agency reviews all cost reports for compliance with administrative thresholds. At least 15 percent of the facilities will be field audited each year using generally accepted accounting principles. Costs will be limited to those costs found reasonable. Overpayments found in audits under this paragraph will be accounted for in accordance with federal regulations.

Allowable Costs

Allowable costs are costs found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed. A cost savings incentive return is a part of allowable cost.

Methods and Standards for Determining Reasonable Cost-Related Payments.

1. The methods and standards for the determination of reimbursement rates to nursing facilities and intermediate care facilities for the mentally retarded is as described in the Nursing Facility Reimbursement manual which is to be included as Attachment 4.19-D, Exhibit B.

2. Payment Rates Resulting from Methods and Standards

Kentucky has determined that the payments rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

3. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Data Resources, Inc. inflation index.

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4. Rates are established prospectively at the beginning of each quarter during the rate year (January, April, July, and October) and will not be adjusted except for mandated cost changes resulting from government actions, to accommodate changes of circumstances affecting patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), and to adjust to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.
 5. The following special classes of nursing facilities are recognized in the Medicaid Program.
 - a. Hospital based nursing facilities are nursing facilities based in hospitals.
 - b. Dual licensed pediatric facilities are nursing facilities serving predominantly children who provide both high intensity and low intensity nursing services.
 - c. NFs with Mental Retardation Specialty (NF/MRSs) are nursing facilities (not including ICF-MRs) with a patient care load including at least fifty-five percent mentally retarded individuals.
 - d. Swing-bed facilities are those hospitals with designated swing-bed units providing nursing facility care in the Medicaid Program in accordance with the swing-bed requirements shown in Title XVIII and Title XIV of the Social Security Act.
 - e. Dual-licensed hospital bed facilities means nursing facility care provided in hospital bed participating in the Medicaid Program as nursing facility beds.
 - f. NF/Institutions for Mental Diseases means those facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.
 - g. NF/Head Injury Units means units recognized by the Medicaid agency as specially designated and identified NF units dedicated to, and capable of, providing care to individuals with severe head injury. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae means a facility appropriately accredited by a nationally recognized accrediting agency or organization such as the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide specialized rehabilitation services.

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- h. Certified distinct part ventilator nursing facility unit means a preauthorized distinct part unit of not less than twenty (20) beds with a requirement that the facility have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter preceding the beginning of the rate year, or upon the quarter preceding the quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The unit shall have a ventilator machine owned by the facility for each certified bed with an additional backup up ventilator machine required for every ten (10) beds. The facility shall be an appropriate program for discharge planning and weaning from the ventilator.
6. Case mix assessments are performed in accordance with Attachment 4.19-D, Exhibit A.
7. Effective October 1, 1990 and continuing until the costs are reflected in the cost reports, the single state agency will add-on an amount to the prospectively determined rates to reimburse for cost incurred to implement the requirements of OBRA 87 as described in Exhibit A.
8. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment. Payments shall be made without comparison to usual and customary or actual billed charges of the provider on a per diem, annual, aggregate or other basis.
9. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.
10. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.
11. Payments will be made by Title XIX (Medicaid) for skilled nursing care for an amount equal to that applicable to Medicare Part A coinsurance amount for the twenty-first through 100th day of skilled nursing care for patients who are eligible for Part A Medicare and admitted to an approved Medicare facility under conditions payable by Medicare.
12. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae shall be paid an all-inclusive (excluding drugs) negotiated rate which shall not exceed the facilities' usual and customary charges.

CERTIFIED DISTINCT PART VENTILATOR
NURSING FACILITY UNIT RATES

Individuals who are ventilator dependent and meet usual high intensity nursing facility patient status criteria may be provided care in a certified distinct part ventilator nursing facility unit providing specialized ventilator services if the care is preauthorized.

Facilities recognized as providing a distinct part ventilator nursing facility unit shall be paid at an all-inclusive fixed rate (excluding drugs which shall be reimbursed through the pharmacy program). A distinct part unit of not less than twenty (20) beds shall be required with a requirement that the facility have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter preceding the beginning of the rate year, or upon the quarter preceding the quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The fixed rate for hospital based facilities shall be \$460 per day, and the fixed rate for freestanding facilities shall be \$250 per day. The rates shall be increased based on the Data Resources, Inc. rate of inflation indicator for the nursing facility services for each rate year beginning with the July 1, 1997 rate year.

Department for Medicaid Services
Nursing Facilities Reimbursement Manual

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TN # 96-10

Supersedes

TN # 90-6

Approved MAY 16 2001

Eff. Date 7-1-96

COMMONWEALTH OF KENTUCKY

Cabinet for Health Services

Department for Medicaid Services

Department for Medicaid Services

NURSING FACILITY PAYMENT SYSTEM

PART I

GENERAL POLICIES AND GUIDELINES

Department for Medicaid Services
General Policies and Guidelines

Nursing Facilities Reimbursement Manual

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100. INTRODUCTION

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A prospective Case Mix Assessment Reimbursement (CMAR) system for nursing facilities providing services for the Department for Medicaid Services (Medicaid) recipients, to be reimbursed by the Department for Medicaid Services, is presented here. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program. This payment method is designed to achieve three major objectives: 1) to assure that needed nursing facility care is available for all eligible recipients including those with higher care needs, 2) to provide an equitable basis for both urban and rural facilities to participate in the Medicaid Program, and, 3) to assure Department for Medicaid Services control and cost containment consistent with the public interest and the required level of care.

The system is designed to provide a reasonable return in relation to cost but also contains factors to encourage cost containment. Under this system, payment shall be made to facilities on a prospectively determined basis for routine cost of care (other than closed head injury programs and ventilator facility patients which have all inclusive rates) with no year-end adjustment required other than adjustments which result from either desk reviews or field audits.

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100. INTRODUCTION

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Ancillary services (other than ventilator therapy services) as defined, shall be reimbursed on a cost basis with a year-end retroactive settlement. As with routine cost, ancillary services are subject to both desk reviews and field audits which may result in retroactive adjustments.

The basis of the prospective payment for routine care cost is the most recent annual cost report data (available and Desk Reviewed as of May 16) trended to the beginning of the rate year and indexed for the prospective rate year. The routine cost is divided into two major categories: Nursing Services Cost and All Other Cost. The routine cost is weighted by the facility's average case mix weight as determined quarterly for each nursing facility. A Cost Savings Incentive factor (CSI) is granted to providers. The system imposes upper limits for nursing services costs and all other cost. Nursing facilities shall be entitled to a hold harmless amount for the period of October 1, 1990 through June 30, 1992.

The payment system also contains various restrictions on allowable cost which are designed to assure that Medicaid payment is limited to the cost of providing adequate patient care.

101.PARTICIPATION REQUIREMENTS

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Nursing facilities participating in the Department for Medicaid program shall be required to have at least twenty (20) percent of its beds but not less than ten (10) beds; for a facility with less than ten (10) beds, all beds participate in the Medicare Program unless the nursing facility has been granted a waiver of nursing facility nurse staffing requirement and as a result, is prohibited from participating in Medicare. If a nursing facility with waiver chooses to participate in the Medicare Program, the facility shall be required to have at least twenty (20) percent of its beds (but not less than ten (10) beds,) if the facility has less than ten (10) beds, all beds participate in the Medicare Program.

A nursing facility or a nursing facility with a waiver may provide and receive payment for high intensity services so long as the services are provided in beds also participating in Medicare programs and a nursing facility or nursing facility with waiver may provide and receive payments for low-intensity services provided in any Medicaid participating bed.

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102. ROUTINE COSTS

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Routine costs are broken down into two major categories: Nursing Service costs and All Other costs. Routine Cost includes all items and services routinely furnished to all patients.

A. NURSING SERVICES COSTS. The direct costs associated with nursing services shall be included in the nursing service cost category. These costs include:

1. Costs of equipment and supplies that are used to complement the services in the nursing services cost category;
2. Costs for education or training including the cost of lodging and meals of nursing service personnel. Educational costs are limited to either meeting the requirements of laws or rules or keeping an employee's salary, status, or position or for maintaining or updating skills needed in performing the employee's present duties;

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102. ROUTINE COSTS

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3. The salaries, wages, and benefits of persons performing nursing services including salaries of the director of nursing and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;
4. The salaries or fees of medical directors, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately; and
5. The costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification or professional standards.

Nurse aide training costs billable to the program as an administrative cost are to be adjusted out of allowable cost.

- B. ALL OTHER COSTS. Costs reported in the All Other Cost category include three major cost centers as reported on the annual cost report: Other Care-Related Costs, Other Operating Costs, Indirect Ancillary Costs, and Capital Costs.

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102. ROUTINE COSTS

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1. Other Care-Related Costs. These costs shall be reported in the other care-related services cost category:
 - a. Raw food costs, not including preparation;
 - b. direct costs of other care-related services, such as social services and patient activities;
 - c. the salaries, wages, and benefits of activities' directors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid program;
 - d. the costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status or position, or to maintain or update skills needed in performing the employee's present duties; and

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